Introduction

The Many Roads toward Achieving Health Equity

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Abstract This special issue of the *Journal* is devoted to understanding the many roads that lead toward achieving health equity. The eleven articles in the issue portray an America that is struggling with the clash between its historical ideal of pursuing equality for all and its ambivalence toward achieving equity in all social domains, especially health. Organized in five sections, the issue contains articles that examine and analyze: the role of civil rights law and the courts in shaping health equity; the political discourse that has framed our understanding of health equity; health policies that affect health equity, such as the Medicaid program, as well as related strategies that might help to improve equity, such as the use of mobile technologies to empower individuals; immigration policies and practices that impact health equity in marginalized populations; and commentaries in the final section that explore how the Affordable Care Act has addressed health equity, how repeal of the law would jeopardize equity gains, and how the political discourse and culture of the Trump administration could adversely affect health equity.

Keywords health equity, health disparities, access to care, fairness

In a special issue whose title contains the phrase "Achieving Health Equity," it is most appropriate to begin by defining the term "health equity." How can we achieve something without first knowing what it is we are attempting to achieve? Although at first blush this intellectual activity seems straightforward, one quickly realizes the complexity involved. There are many definitions of health equity in the literature, a notable recent example is that of Paula Braveman (2014), who clearly distinguishes between the terms "health disparities" and "health equity." She

begins by using the Healthy People 2020 (CDC 2017) definition for health disparities:

> . . . a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

This definition makes clear that not all health differences should be defined as health disparities. In Braveman's view, and in our view in this volume, a *health disparity* is a health difference that is explained by social or economic factors other than illness, such as race, ethnicity, income, and education. Such disparities are unjust. We all are born with different health endowments and we make choices in life that impact our health along the way. However, when these endowments and choices, coupled with our experiences, are historically (and currently) linked to discrimination or exclusion, the observed differences in health raise issues about social justice. Indeed, this concern about social justice lies at the heart of the concept of health disparities (Braveman 2011, 2014).

It makes sense, then, that after years of documenting myriad health disparities based on race, ethnicity, gender, education, and socioeconomic status (Adler and Stewart 2010; Krieger 2001; WHO 2008), researchers, policy makers and advocates recently have shifted their focus from documenting the existence of disparities to addressing the underlying causes of those disparities. Indeed, the recent focus on *health equity* reflects growing interest in the social determinants of health and the pursuit of high-value health care in the United States (Adler et al. 2016; Betancourt 2016; Purnell et al. 2016; Thornton et al. 2016). It also represents a common goal to eliminate disparities in health. However, while this goal illustrates a consensus that health disparities are unjust and need to be addressed, it also likely masks policy disagreements regarding how to go about achieving health equity.

Braveman (2014) defines health equity as the pursuit of "striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social

conditions" (p. 6). Although this definition offers some clarity, the term "possible standard" still allows for unequal distribution of health and raises the question (as we discuss below): How do we determine the highest possible standard of health? Moreover, it remains unclear what public policies or set of programs would bring us closer to achieving this goal. The lack of consensus stems not so much from an unresolved debate over the choice of solutions but rather from an implicit acknowledgment that many different approaches have been (and still could be) offered in service of achieving this goal.

For example, in attempting to attain the highest possible standard of health for all, some may argue that we need to focus on a model of patient engagement in which the patient is given full volition to pursue her own "highest possible standard of health" even if that results in an unequal distribution of health for all. This approach fits with the "process" view of equity (Nozick 1974), where the focus is on the fairness of the decision-making process, rather than the end result. Voting is a classic example of process equity: although only one person wins, people accept this result as fair and legitimate as long as the voting process is deemed fair. In contrast, others might argue that we should look at health outcomes (the end result) to determine if health equity has been achieved. What is important about the health domain is that although these two arguments are simultaneously in play, rarely are they ever debated as alternatives. Rather, complementary approaches to achieving health equity typically (and arguably must) happen across the divide between process and end results as well as across multiple levels of scale. The purpose of this special issue is to examine the broad array of approaches that have been attempted in the United States to address health equity through legal, social, and public health interventions, and to elucidate the political challenges that have affected how various policies—whether so intended or not—have resulted in better or worse health equity.

To illustrate this point we provide a conceptual framework that displays approaches to health equity across a process versus end results continuum (see fig. 1). As is the case in all countries, there are laws and regulations that dictate how providers deliver health care and how patients should be able to access care in a "fair" way. The term "fair" is in quotations because whether laws and regulations actually provide access to care in a fair way is subject to interpretation and therefore always contested. Contributors to this issue address different elements of process or end results within the framework.
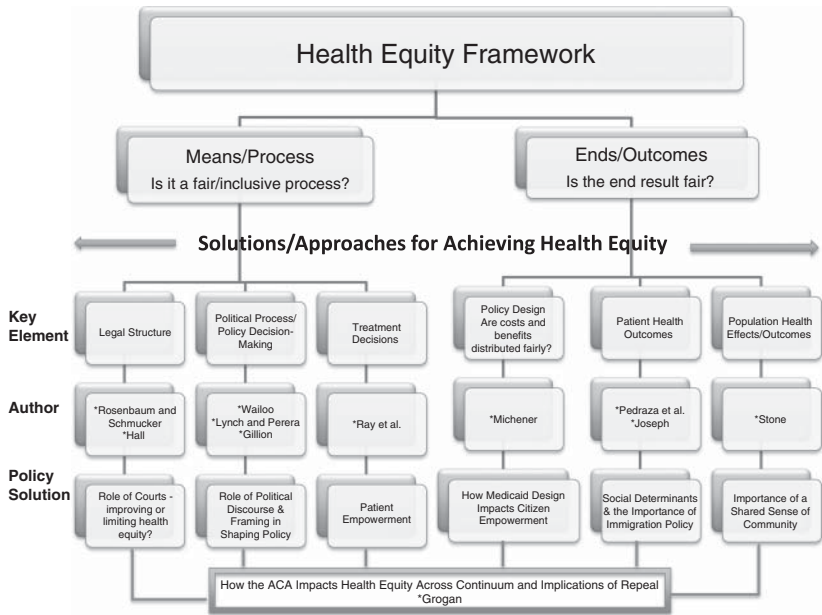
Figure 1 Health Equity Framework

In This Issue

The special issue is presented in five main sections. Articles in the first section examine the importance of civil rights and the role of the courts in shaping health equity. The second section contains three articles that document and analyze the political discourse that has framed our understanding of health equity and the policies that have been developed to address health disparities. The third section focuses on health policies that affect health equity, such as the Medicaid program, and on practical strategies that might help to achieve better equity, such as the use of mobile technologies to empower individuals. In the fourth section, two articles explore how immigration policy and practices impact health equity in marginalized populations. The issue concludes with two commentaries that analyze how the Affordable Care Act has addressed health equity, what repeal of the law would mean for equity, and how health equity will be affected more broadly by the political discourse and culture of the Trump administration.

We summarize here the salient points raised in the articles that follow. Looking back over the past fifty years, Mark Hall argues that the courts have played a limited, yet key, role in shaping health equity by impacting

legal rulings and understandings in three main areas: racial discrimination, disability discrimination, and constitutional rights. Hall contends that the impact of the courts on health equity has been limited, largely because judicial enforcement has focused on overt, intentional discrimination in the delivery of health care, which is largely absent in the modern era. Thus far, the courts have been unwilling to use civil rights or constitutional law to address documentation of health disparities or of disparate impact by race or gender.

Sara Rosenbaum and Sara Schmucker focus specifically on Title VI of the Civil Rights Act of 1964, which prohibits discrimination by federally assisted entities on the basis of race, color, or national origin. Despite the major achievement of enforcing rapid desegregation of hospitals in the 1960s, a major limitation of Title VI has been the courts' refusal to apply the title to physicians, allowing them to remain free to refuse to accept particular patients. Rosenbaum and Schmucker also discuss the very important distinction between discriminatory impact and intentional discrimination, and the refusal of the courts to consider legal challenges to the former. Nonetheless, they conclude on a positive note, citing a recent resurgence to use Title VI to enforce basic compliance across a range of federally assisted programs. These two articles highlight the importance of having a strong legal framework in place to move the nation toward greater health equity.

Health equity also has been shaped historically through political discourse and the ways in which we have framed the issue itself. Using cancer care as a vehicle to illustrate his points, Keith Wailoo traces the transition of scholarly discourse from a focus on "health disparities" and "inequalities" to a more refined focus on "health equity." He argues that the shift is not purely semantic, but rather a political strategy to narrow the target of health reform efforts in the current era. Thus, he believes that the history of cancer and race may hold valuable lessons for the "long and winding road" of health reform related to improving health equity for all.

Julia Lynch and Isabel Perera explore the different conceptions of health equity in key national health policy documents in the United States, the United Kingdom, and France. They find substantial differences across the three countries in the characterization of group differences (by socioeconomic status or SES, race/ethnicity, or territory), and the underlying theorized causes of health inequalities (socioeconomic structures versus health care system features). Although reports in all three countries allude at least minimally to inequalities in social determinants as the underlying cause of health inequalities, the reports' authors stop well short of advocating the redistribution of power and resources that likely would be necessary to redress observed inequalities.

Examining the different rhetorical approaches used by US presidents since the 1960s to address minority health inequality, Daniel Gillion offers both a historical perspective and an empirical assessment of how that political discourse transported their discussion of minority health beyond the confines of Washington, DC, to local communities throughout the nation that had disproportionate numbers of blacks and Latinos. He finds that presidential discussion of minority health leads to greater salience on the issue and increases public health awareness. His work suggests that presidential messaging on minority health provides a framework for minority groups to understand and discuss the health disparities that may plague their communities.

The article by Jamila Michener focuses specifically on the political effects of concentrating Medicaid beneficiaries in particular locales. She first presents a framework for conceptualizing the community-wide consequences of policy concentration, and then analyzes aggregate longitudinal data to examine the effect of Medicaid density on county-level voter turnout and local organizational strength. Michener discovers that, as the proportion of county residents enrolled in Medicaid increases, the prevalence of civic and political membership associations declines and aggregate rates of voting decrease. Her findings suggest that, if grassroots political action is to be part of a strategy to achieve health equity, policy makers and local organizations must strive to counteract the demobilizing "place-based" political effects of "people-based" policies such as Medicaid.

Rashawn Ray and colleagues explore the potential for advances in technology to overcome racial barriers to health equity. Specifically, they examine how mobile online technologies may allow people to access and utilize health care in innovative ways. Using national survey data, they analyze racial differences in obtaining health information online via mobile devices, finding that blacks and Latinos are more likely than whites to trust online newspapers to get health information, and that minorities who have access to a mobile device are more likely to rely on the Internet for health information in a time of strong need. Federally insured individuals connected to mobile devices display the highest probability of relying on the Internet as a go-to source of health information. The authors conclude that mobile technologies may hold promise for helping to develop health literacy, improving health outcomes, and contributing to the reduction of health disparities by race and health insurance status.

Immigration policy and health policy have become increasingly intertwined in the twenty-first century, and there is growing evidence that

health care utilization among Latino immigrants is adversely affected by restrictive immigration policy. Francisco Pedraza and colleagues investigate how immigration politics may negatively influence health care utilization among Latino US citizens, and the implication that health insurance expansions may not reduce health care inequities among Latinos who are concerned about exposure to immigration law enforcement authorities. Using data from the 2015 Latino National Health and Immigration Survey, they examine the extent to which the politics of immigration deters individuals from accessing health care providers and service-providing institutions. They find that Latino US citizens are less likely to make an appointment to see a health care provider when the issue of immigration is mentioned. Additionally, Latino US citizens who know someone who has been deported are more inclined to perceive that information shared with health care providers is not secure. The authors discuss how cautious citizenship or risk-avoidance behaviors toward public institutions in order to avoid scrutiny of citizenship status can be integrated into the formulation of policies aimed at reducing health care inequities.

Immigration policy also casts a shadow over recent health reforms. For example, most immigrants are excluded from the 2010 Affordable Care Act (ACA) owing to federal restrictions on public benefits for certain immigrants, but some states have extended coverage options to federally ineligible immigrants. In an examination of the relationship between coverage and health care access for immigrants under comprehensive health reform in the Boston metropolitan area, Tiffany Joseph finds that survey respondents across various stakeholder groups perceive that immigrants' documentation status minimizes their ability to access health care even when they have health coverage. Specifically, respondents express concern about the increased likelihood of deportation en route to medical appointments, which negatively influences immigrants' health care access. Thus, she believes that restrictive federal policies and national-level anti-immigrant sentiment can undermine inclusive subnational policies in socially progressive places.

In a concluding commentary, Colleen Grogan recounts the positive impacts of the ACA on achieving health equity and points to the dangers of repealing and replacing certain provisions of the law. It is no accident that the ACA explicitly mentions "health disparities" thirty-five times, or that all ten Titles of the Act contain efforts to reduce or eliminate such disparities. Although the ACA was not designed to overcome all health inequities, she explains how the specific provisions under each Title

enable state and local governments, health care delivery programs, and providers—to name just a few of the actors—to put policies in place that begin the work of moving toward achieving health equity. Her analysis of the chief replacement bill, the American Health Care Act, indicates that, if passed by Congress, it will steer the nation further away from (rather than toward) achieving health equity.

In a companion perspective, Deborah Stone underscores the importance of equity as a political aspiration that transcends a philosophical standard for distributive justice. She presents strong arguments that equity can be sustained only through a culture of community in which people share an abiding sense of sameness and are actively willing to help other members of their community who are in need. She draws upon other articles in this issue to support her contention that the ACA's provisions regarding anti-discrimination must be preserved, and that the Trump administration and Congress should tread lightly when seeking to repeal and replace the ACA. Stone concludes by urging policy makers, policy analysts, and concerned citizens to resist policies that would undermine health equity and to remain focused on our national political and cultural institutions that make good policy possible.

Taken together, these eleven articles portray an America that is struggling with the disconnect between its historical ideal of pursuing equality for all and its demonstrated ambivalence toward achieving true equity in all social domains, especially health. Past failures to achieve health equity have been due, in part, to limitations in our laws and to unbalanced enforcement of those laws. But past efforts also have been limited by the restrictive ways in which health equity discussions have been framed and by health policies that, despite good intentions, have tended to be poorly designed and targeted for overcoming health inequities. Thus, there is a growing need to experiment with innovative strategies to improve health equity and, most importantly, to recognize and address the intersections that exist between health policies and other social policies, most notably immigration policy. As Colleen Grogan and Deborah Stone articulate in their commentaries, our nation is facing grave political challenges to our cultural institutions and our long-held ideals. The health equity gains achieved through ACA reforms are threatened by efforts to repeal and replace the law. While it is difficult to predict how events may unfold, it seems imperative that we rise to the stated challenges and muster the necessary political will to plot a clear course toward achieving health equity.

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